NORTHUMBERLAND & DURHAM

MEDICAL SOCIETY.

THURSDAY, DECEMBER 6, 1883.

CONTENTS.

PREVALENT DISEASES OF THE DISTRICT.

PATHOLOGICAL SPECIMENS.

EXHIBITION OF PATIENTS.

SEQUEL TO A CASE OF OVARIOTOMY.

By JAMES MURPHY, M.D., B.A., &c., Surgeon to the Sunderland Hospital for Women and Children.

REPORT OF A CASE OF GASTROSTOMY, WITH REMARKS.

By G. H. HUME, M.D., Surgeon to the Newcastle Infirmary.

OSTEOID CANCER (OR MALIGNANT OSSEOUS TUMOUR) OF KIDNEY.

By JAMES ADAMSON, M.D.

SEQUEL OF THE CASE OF OBSCURE TUMOUR OF THE BACK OF THE THIGH SIMULATING ANEURISM, SHOWN AT THE OCTOBER MEETING, WITH SPECIMEN AND PATIENT.

By FREDERICK PAGE, Surgeon to the Infirmary, Newcastle-upon-Tyne.

ERRATA.

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NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

THE THIRD MONTHLY MEETING was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, December 6th, 1883 —The President (Dr. Arnison) in the chair.

The following gentlemen were elected members of the Society :—

James Drummond, M.D. Glasg., South Shields.
Percy Blumer, L.R.C.P. and L.R.C.S. Edin., Sunderland.
Philip Atkins Pearcey, M.B., C.M. Edin., Sunderland.
G. B. Craig, M.R.C.S. Eng., Willington-on-Tyne.
Chas. H. Milburn, M.B. Durh., County Hospital, Durham.
Chas. George Maclagan, M.B., C.M. Edin., Ravensdowne, Berwick-on-Tweed.

The following gentlemen were proposed for election :—

George Henry Taylor, L.R.C.P., L.R.C.S. Edin., Sedgefield.
A. M. Vann, M.R.C.S. Eng., L.S.A. Durham.

The SECRETARY, in Dr. Wicks' absence, called the attention of members to a petition to Parliament, which was lying on the table for signature, praying for the abolition of the *carriage tax*.

DISCUSSION ON THE PREVALENT DISEASES OF THE DISTRICT.

Mr. HENRY E. ARMSTRONG forwarded the following :—

Return of Admissions to and Deaths at the Newcastle Fever Hospital during the month of November, 1883.

Disease.	Admissions.	Deaths.
Scarlet Fever	3	0
Typhus ,,	1	0
Enteric ,,	4	0
Continued Fever*	2	2
Total	10	2

* In neither of these was the character of the fever defined.

PATHOLOGICAL TRAY.

Mr. PAGE said: These urinary calculi, 65 in number, were removed at intervals during a period of some 24 months from the urethra of a man by Dr. A. Wood, of Kirkby Moorside, and I am indebted to that gentleman very much for his kindness in allowing

me to bring the case under the notice of the Northumberland and Durham Medical Society. Each calculus seems to have a nucleus about the size of a large shot, and the coating consists of phosphatic matter. Some of them have undergone spontaneous division in the bladder. They are much of the same size, polished by friction, and bear a strong family resemblance to each other; indeed, like the gentry whose acquaintance Rip Van Winkle made in the Catskill Mountains, they appear to be all brothers. I regret that I am unable to give any detailed history of the case. Dr. Wood tells me the man lived some 12 or 14 years after the extraction of these calculi, and continued during the whole of that time to void two or three calculi, about the size of a 5-grain pill, weekly. Dr. Wood had passed a catheter, for the relief of retention, almost daily for five or six weeks without striking a stone, and this is a curious and instructive feature in the case, for at that time, up to December, 1859, there must have been many calculi in his bladder. In January, 1860, the first calculi were removed, five in number. Dr. Wood was called to the man, who lived a considerable distance from his house, during the night, and found the urethra blocked by a calculus. He had no instrument with him to extract the stone with, and got the blacksmith of the village to turn the point of a horse-shoe nail, and with this rude but efficacious tool removed, as I have said, 5 calculi, and on subsequent occasions the 60 others. Only two of the stones passed by the patient, subsequent to the extraction of the 65, have come into my possession, and they, as you see, differ much in size and appearance from the ones removed by Dr. Wood.

EXHIBITION OF PATIENTS.

Dr. Drinkwater said: Mr. President and Gentlemen,—The case which I have the pleasure of bringing to the notice of this meeting is one, I take it, of no common interest. It proves clearly that under certain favourable circumstances it is possible to interfere in a very decided manner with pathological processes going on in the lungs. The gentleman is 63 years of age, a minister, and recently editor of one of the Methodist denominations. In 1846 he had acute articular rheumatism. In 1850 he had what was called by his medical attendant a psoas abscess, which invalided him several months, and was treated by incision and drainage. In 1869 he had "low fever," and shortly afterwards began to suffer from mental depression and irritability, which entirely prevented him doing literary work. In the autumn of 1880 he was confined to bed a fortnight by acute bronchitis. His last illness, and the one with which we are now specially concerned, began in the spring of 1881

with a very harsh cough. It was not accompanied by expectoration, and on stethoscopic examination I was unable to detect sufficient to account for so violent a cough. The uvula, however, seemed elongated, and the pillars of the fauces relaxed. I treated it with a strong solution of nitrate of silver, and this somewhat relieved the cough for a short time. It had a harsh ringing sound, which was particularly disagreeable not only to the patient but to all who heard it. In August of the same year he married his second wife, fortunately for him, as she has proved herself a most excellent nurse; but shortly before this he had begun to complain of weakness and great fatigue after moderate exercise, and especially when ascending stairs or climbing a hill. In September he commenced to expectorate tough mucus, and shortly afterwards it became purulent and had a very offensive odour. My diagnosis now was peribronchial abscesses, resulting probably from the rupture of the walls of some small bronchi by the harsh straining cough. On October 29th, Mr. Morgan visited him with me, and confirmed my diagnosis. The treatment consisted in use of abundance of plain nourishing food, sedatives, aq. chlorinii, ol. morrhuæ, and an inhalation composed of ac. carbol., iodine, and alcohol. At this time there was nothing wrong noticeable in the cardiac sounds; certainly there was no murmur. The symptoms continued without amelioration, and on the 5th of December he complained of an acute, cutting pain over the front of the upper portion of the left lung, catching the breath on inspiration. On examination, I found distinct dulness, extending from apex to third rib, with deficient expansion during inspiration, and an entire *absence* of vocal resonance. The expectoration was tinged with blood, and now a distinct blowing murmur could be heard over the tricuspid area. On December 10th Dr. Philipson visited the patient, and confirmed my diagnosis of embolism of apex of left lung, and acquiesced in the treatment adopted, but recommended in addition the external application of iodine over the seat of disease. The patient's health now began to decline very rapidly, and by the New Year gangrene had set in, and he was in a very critical condition. There was a pinched and pallid countenance, hot and dry skin, loss of appetite, distinct constipation, a temperature oscillating about 103° F., with nocturnal elevations and profuse perspiration, and the expectoration soon became greenish and sero-purulent. During first week of the New Year (1882) a slight swelling was observed in the subclavicular region, and I then began to suspect carcinoma, but it increased too rapidly. It was painless and firm to the touch. On the 16th of the month Mr. Morgan again saw the case, and at this time we could make out deep fluctuation. There was evidently pus beneath the pectoral muscles, and as it appeared to be burrowing and not coming to

the surface, Mr. Morgan recommended that poultices should be applied for two days. On the 18th we found the swelling emphysematous—there was evidently a free communication between the abscess cavity and a bronchus through an intercostal space. I made a free incision over where I thought the intercostal aperture would most likely be. Very offensive air escaped immediately the skin was incised, but the pus was not reached until the pectoralis major and a tolerably thick layer of adipose tissue covering it were divided. This pus was extremely fœtid and discoloured. On introducing my finger into the wound, I came at once upon a small circular foramen in the intercostal space; a drainage tube was introduced into the wound, and thick gauze dressings applied. The symptoms ameliorated for a week or two, but the prostration increased, so that he could, with difficulty, walk across the room, and always regarded it as a noteworthy feat if during the forenoon he had been able to walk three or four times round the dining-room table. By the middle of March there was considerable emaciation, and the usual appearances and symptoms of hectic were present. The temperature rose to 104°, the pulse to 130, and the respirations to 40 *per* minute; no sleep could be procured, and there was slight diarrhœa, and the putrid odour was perceptible immediately on entering the house. Death was imminent, when on the 21st of March I again consulted with Mr. Morgan, and he agreed that the only chance of prolonging life lay in making a free incision into the chest, at the seat of the disease, for the discharge from the wound had continued profuse and offensive, soaking the dressings three or four times a day, while almost as much was expectorated. On the following day (March 22nd) Mr. Morgan very kindly administered æther, by means of Coxeter's apparatus, and I performed the following operation:—By enlarging the first wound, I made an incision about four inches long; I then introduced a probe-pointed bistoury into the intercostal aperture, and divided the intercostal muscles from this point outwards for an inch-and-a-half. I then removed one-and-a-quarter inches of third rib by means of a small saw, thus making an opening sufficiently large for the purposes of exploration and drainage. The pleural cavity, of course, was obliterated at this point. I could feel that the upper portion of lung was quite solid, but pulpy—in fact it was in the condition of gangrene. I broke it up with the finger, as much and as far as I could in all directions, and incised it slightly with the bistoury, and then considerably with the handle of the knife, in order to facilitate its subsequent evacuation through the drainage tube. I introduced a drainage tube of large calibre (about $\frac{3}{8}$-inch), and it extended fully two inches horizontally backwards within the thoracic wall, and, therefore, into the lung substance. The dressings were applied as before.

We hoped for good results ultimately, but the *immediate* results were certainly beyond our expectations, for on the following morning, 24 hours after the operation, the temperature had fallen to 100 deg.; pulse 105; respiration 34; and from this time steady, though of course slow, improvement followed, and on the 21st day after the operation the patient went down stairs. The tube was taken out and washed twice a-day, and a small quantity of a solution either of permanganate of potash or carbolic acid was injected into the wound. This had to be done with the least possible force, or else it caused very violent coughing, and was expectorated, for the patient could taste it. The discharge gradually diminished, became simply purulent, and lost the offensive smell which had previously characterised it. After September the tube could no longer be passed through the intercostal space, and it had frequently to be shortened, so that by the end of October, only one inch could be introduced (instead of five inches, the original length), and it was then entirely dispensed with. By the end of November the wound had entirely healed, and only a firm cicatrix remained. Considerable falling in of the subclavicular region had occurred, and the site of the apex was represented by a large cavity. He now was gaining flesh with tolerable rapidity, and is at the present time almost as well as he had been for a year or two previously to the commencement of this illness, and, as you will observe, is by no means deficient in flesh. This case was favourable for operative interference, because the diseased part was sharply marked off from the healthy portion of the lung; and were I to get a similar case, or one in which there was evidently one large circumscribed gangrenous portion of lung, and not several small patches, if death seemed inevitable, and nature did not (as it certainly *did* in this case) indicate the method of cure, I would not hesitate to cut down upon the diseased part, wherever it might be, and establish free drainage as in this patient.

Dr. Dyce Duckworth (London) expressed much interest in Dr. Drinkwater's case, the like of which he had never met with. He was not clear as to the exact pathology of it. The physical signs seemed to indicate a patch of pneumonia near the apex of the left lung, but these signs were not perfectly significant. Dr. Philipson's opinion as to infarction seemed to require further explanation, for it was surely not common to meet with this in the absence of well-marked cardiac disease, which did not exist in this patient. There could be little doubt that some inflammatory change had occurred, leading to degradation of the products of it, and to localised gangrene. It was eminently satisfactory that an outlet for this had taken place, albeit in so unusual a manner, and Dr. Drinkwater deserved much credit for his conduct of the case, which was highly encouraging and instructive.

Dr. DRUMMOND thought the Society was much indebted to Dr. Drinkwater for affording the members the opportunity of examining such an interesting case. He was sure all present would congratulate Dr. Drinkwater upon the success of his treatment. It was another proof of the advance of surgical science. The surgeons had long since explored and invaded the abdomen, and now they were attacking the thorax. He referred to the plan of excising a portion of a rib when the intercostal spaces were too straitened to admit of free drainage, and stated that he had found it of great value in cases of empyema. He also would be glad if Dr. Drinkwater would explain more fully his views on the pathology of the attack of gangrene of the lung.

Dr. PHILIPSON expressed his pleasure at the introduction of the patient, not only at the interest of the case, but also at the means that had been had resource to in the treatment. At the time he had visited the patient, in consultation with Dr. Drinkwater, the case was a very serious one, and, in consequence of the shock to the system from the hæmorrhagic infarction of the lung, there was fear that he was sinking. He revived, and then passed through the additional danger of the irritation of the lung from the foreign material. He agreed with Dr. Drinkwater as to the sequence of events, and as to the explanation of the physical signs alluded to.

Mr. MORRANT BAKER (London) thought Dr. Drinkwater was to be heartily congratulated on the brilliant result of his exploratory operation on the thorax of the patient now exhibited to the society. The case was an excellent example of the value of the now generally adopted surgical *dictum*—that in whatever part of the body decomposing matter is confined and giving rise to constitutional symptoms, it should be searched for and, if possible, let out. Scarcely any organ or region of the body can be now looked upon as safe from intrusion on the part of the surgeon The abdominal cavity in general, the kidney, the liver, the cranium, the thorax, the lung, are all now explored when it seems advisable.

With reference to the removal of portions of one or more ribs, Mr. BAKER said he could speak from experience of the value of the proceeding, as he had on more than one occasion performed the operation in cases of empyema, and with much benefit so far as drainage was concerned.

The PRESIDENT said he thought a well-known phrase often used to express completeness and perfection might be applied to the case and to the patient, viz., "teres, totus, atque rotundus."

Dr. DRINKWATER said, in reply: Dr. Duckworth spoke of an "exudation" and "abscess," and appears to think that the case was

one of abscess of the apex of the lung, but it could not possibly be *that*, and for the following reasons: the patient complained of a sudden pain on the day referred to, in December, and on examination I found dulness extending to third rib, the expectoration was tinged with blood for the first time, and there was a tricuspid murmur. Now, I can affirm positively that *there was no dulness on the previous day;* in fact, up to this time there could be detected by stethoscopic examination scarcely any signs of disease, and I always examined the apices very carefully, and should certainly have detected consolidation at the very outset. There was undoubtedly embolism of the lung, and a blowing murmur over tricuspid area. Dr. Philipson has told us that when he visited the patient in December that he found him in a critical condition, but he was in a much more critical state in the following March, when the system had been drained for two months by a profuse sero-purulent discharge from the wound, and an expectoration of the same nature and almost equal in quantity. I beg to thank the gentlemen who have spoken of the case in such flattering terms, and I would desire to express my indebtedness to Mr. Morgan for his valuable assistance and advice.

Mr. T. A. Dodd, in introducing a patient whose right patella had been excised for caries of that bone, said: This patient, sir, was admitted an in-patient of the Newcastle-on-Tyne Infirmary, about the middle of September. At that time the integuments covering the centre of the patella were ulcerated to about the size of a shilling, exposing dead bone to a similar extent. On the 25th September I proceeded to remove the dead portion with a gouge, but found the whole extent of the bone softened and carious, breaking down under the instrument. It was then evident that nothing short of complete excision would be of any service. I therefore made a crucial incision through the skin covering the joint, and removed the whole patella. The knee-joint was very fully opened up, the articular ends of the femur and tibia being exposed to view, and the whole of the synorial fluid escaped. The edges were brought carefully together with catgut sutures, and a drainage tube put into the joint. This was done under strict antiseptic precautions. The limb was placed on a back-splint, with foot-piece. The wound into the joint healed by first intention, the tube being withdrawn at the first dressing, a small skin ulcer being left. This healed rather slowly, and at the end of six weeks was completely closed. The wound was only dressed antiseptically six times, and there was never any elevation of temperature except once, on the 12th October, when it reached 101°, a fortnight after the operation. The splint was removed about the middle of November, when it was found that the patient had very fair movement in the joint; and now you will observe that she

has full power of extension, and can flex the knee almost to a right angle. To-night she has walked nearly a mile without assistance to come to this meeting. Not having read or heard of any case of the kind, I wrote to Professor Lister asking him if any similar case had occurred in his practice. He courteously replied : "*So far as my knowledge goes your case is unprecedented as regards its results.*"

Mr. Morrant Baker congratulated Mr. Dodd on the recovery of his patient with such excellent power of extension of the leg, notwithstanding the complete removal of the patella. At first sight it might seem almost impossible to extend the leg after the patella had been taken away, but, of course, this bone was anatomically only a sesamoid bone in the midst of a very wide tendinous expansion, a great part of the continuity of which would not be affected by the patella's removal. This anatomical arrangement accounted also (as remarked in a recent discussion) for the fact that, when in operations for the re-union of the fragments of a broken patella, it was necessary to divide the quadriceps tendon immediately above the bone. This division did not of necessity interfere afterwards with the power of extending the leg.

Mr. Page showed a man whose ununited patella was ligatured on November 17th, and said: This case, sir, will, I think, be of interest to the Society at the present time—when the propriety of ligaturing the patella is exciting so much attention. It is, moreover, I believe, the first case of the kind which has occurred in the Newcastle Infirmary. The man is 54 years of age. Twelve years ago he fractured his right patella, and since then he has been obliged to wear a leather support, by means of which, though very lame, he has been able to work as a horse-keeper in a coal pit. Twenty-one weeks ago a pony kicked him, fracturing his right leg just below the knee-joint, and causing, by direct violence, a comminuted fracture of the left patella. On admission to the Infirmary, November 10th, he was quite unable to stand. He could move his legs freely when lying. The right patella was drawn up $2\frac{1}{2}$ inches above the joint, and no lower fragment could be felt. The fracture of the leg was united well. There was an interval of $1\frac{1}{2}$ inches between the fragments of the left patella. On November 17th, the left patella was cut down upon, and the fragments, perforated and fastened together with silver wire, which was then twisted and the ends hammered flat. The upper fragment was large, and easily pierced with a common brad-awl; but the lower portion was very small, and consisted of two pieces connected together by fibrous material. It was difficult to pass the wire through the lower portion so as to feel sure that it would hold, so that I pierced the tendon beyond, and so brought the upper and lower fragments into close contact. Two drainage tubes were then introduced into the

joint, one on the outer, the other on the inner side, and the wound closed with a continuous suture of cat-gut. Here is the temperature chart, which shows no rise above 100. It is premature to say what the result of the case will be, as regards the usefulness of the limb; but, as far as the operation is concerned, there has been no ground whatever for anxiety, and I show the case in its present stage to bring that circumstance prominently before the members of the Society.

Mr. Morrant Baker thought Mr. Page's case one of great interest, especially at the present time, when so much attention had been drawn to the question of operation in cases of broken patella. In the present instance there was an obvious reason for endeavouring to secure as perfect union of the fragments as possible. But with regard to the exposure and wiring of the fragment of a recently broken patella, Mr. Baker felt that the proceeding was not, in a large majority of instances, either wise or beneficial. In most cases of fractured patella, properly treated, recovery took place with as good result, practically, as after the most successful cases of operation. Without doubt the risk of the operation was not great, in recent cases, but it could not be absent altogether; and if a bad result happened in only one case out of fifty, or even more, the disaster would not be compensated for by the good results in the remainder. As a fact bad results had occurred: anchylosis, suppuration, amputation, and even death; although chiefly in cases in which old fractures had been operated on. It therefore seemed that, for recent cases, the operation should not, under the ordinary conditions of the accident, be performed at all; and that in the older cases, it should only be performed when the limb was, in consequence of want of union of the fragments, comparatively useless.

Dr. Murphy said: I have listened with very great interest to the remarks of Mr. Morrant Baker, and while, from want of experience, I must refrain from committing myself to an opinion as to whether this operation should be recommended at all, and if it should, in what cases, still I must own that my views are very much in sympathy with those expressed by Mr. Baker; and, in addition, I would point out that though Mr. (now Sir Joseph) Lister, describes the operation as being free from danger, and giving rise to no constitutional disturbance or other cause for anxiety, yet, when describing the necessity of having the bandages properly secured, he confesses that one of his patients became delirious after the operation, so that one feels it would be more satisfactory to have more complete details of each of the cases recorded. We must all have seen cases with wide separation of the fragments, where the limb was practically as good as its fellow. I have in my possession

a cast of a fractured patella where the fragments are connected by a ligament over two inches long; and though I had seen the patient for some weeks, for another disease, I only discovered the fracture by accident, so well did he walk; in fact, it was only in walking down hill that he found any difference between his legs.

Dr. Gowans said he merely wished to express the pleasure he had received while listening to the remarks of Mr. Baker on the treatment of fracture of the patella. He had arrived at similar opinions from studying the debate on the subject before the London Medical Societies. There could be no doubt it was justifiable to open the knee-joint in such cases as those of Mr. Dodd and Mr. Page; there being a useless limb, and ordinary treatment having failed. Not so, however, he thought in recent fracture. He fully appreciated the safety which the antiseptic method had conferred on operations upon joints; nevertheless, accidents in the most careful hands did occasionally happen, and therefore the operation by incision and suture was not altogether unattended by danger. Happily, as Mr. Baker had so well said, the procedure was unnecessary, for, as a rule, a perfectly good result was obtained by ordinary means. The last case which he had treated was fracture of both patellæ, caused by the patient jumping from a vessel on to a stage landing, and, slipping backwards, made a violent effort to recover his balance. By the usual treatment of flexing the extensor muscles of the thigh and bandaging, the man walked perfectly in a few weeks. He considered that Lister's operation of binding the fragments by wire suture valuable for exceptional cases.

The President said he had been long of opinion that close ligamentous union gave results quite as satisfactory as bony union, and instanced three cases which he had treated some years ago, occurring nearly together, in one of which bony union took place, but caused great trouble to prevent a stiff joint; in the other two ligamentous union resulted, and the patients walked as well as the one with bony union, if not rather better, and with no trouble as regards a stiff joint.

Mr. Page showed a boy upon whom tracheotomy was performed for croup, during the last meeting of the Society, and said: At the November meeting, while the discussion on tracheotomy was going on, this boy was sent to the Infirmary, by Dr. Redmond, of Gateshead, for the purpose of having tracheotomy performed for the relief of very urgent symptoms due to croup. The trachea was opened above the isthmus, and the lad has made a good recovery. My own experience of tracheotomy, in cases of croup, like that of other members of this Society who spoke upon the subject at the last meeting, has been so exceedingly unsatisfactory, that I am glad to be able to show this successful result.

SEQUEL TO A CASE OF OVARIOTOMY.

By JAMES MURPHY, M.D., B.A., &c., Surgeon to the Sunderland Hospital for Women and Children.

Mr. President and Gentlemen,—At the March meeting of this Society, in 1882, I had the pleasure of showing a large multilocular tumour of the left ovary, which I had removed, on January the 16th previously, from a patient kindly sent to me by Dr. Adamson, of Hetton-le-Hole; having described its removal I went on to say, as reported in our transactions:—"On examination the other ovary was found increased to about double its normal size and divided into several cysts, but it had not yet become pediculated, and the ligament was so very tense that I deemed it inexpedient to remove the tumour with the knife, as it would have been very difficult, if not impossible, to secure the stump with a ligature; and not having sufficient confidence in the cautery, I passed two ligatures underneath the ovary, and then tied both as tightly as I could, at opposite sides of it, pretty much in the same manner as if it were a nævus. I then punctured each of the cysts." The operation, which was done with the strictest attention to antiseptic details, was then completed in the ordinary manner; the patient made an excellent recovery, was up on the twelfth day, never having had a bad symptom of any kind, the wound requiring dressing only four times, and she was at the time of the report, March the 9th, in excellent health and spirits. I then pointed out that the chief interest of the case lay in the treatment of the right ovary, as it was the first time such treatment had been tried, and I concluded by saying: "I hope that the strangulation to which it has been subjected to may destroy an organ so complex in its structure as an ovary; though, as is well-known, it has but little effect on the hardier tissue of the pedicle, a very good example of which I exhibited to the Society some years ago, which I obtained from a subject on whom I had performed ovariotomy a year previously, where the distal portion of the stump remained beyond the furrow which marked the site of the ligature. It will be a matter of much interest to watch the after-history of the case, and see if the ovary gives trouble hereafter." Now, Mr. President, it has been a matter of much interest, indeed, to watch the after-history of the case which I now relate. The right ovary has given further trouble, for on June the 9th of the present year she was delivered of a living male child. I am indebted to Dr. Taylor, assistant to Dr. Adamson, for the following careful and accurate notes of the case:—

"Mrs. J., age at first delivery 21 years; number of children six; miscarriages none; fifth child born a year before ovariotomy performed, January 16th, 1882; menstruated third day after operation;

and for nine months menstruated regularly every month, 'the same as she always was,' before her illness; delivery 9th of June; head presenting ruptured membranes; over in three-quarters-of-an-hour; pains strong and quick every few minutes; could not lie on left side; dorsal posture; no tenderness of abdomen; no hæmorrhage; never had a bad symptom; and they both are in excellent health at the present time."

Such, then, is the brief after-history of the case; now to account for it. It may be explained in several ways. It may be taken for granted that a portion of an ovary at least is necessary for conception, and it may be suggested in this case that a third ovary was present, several examples of which have been reported, indeed Courtey relates (page 764, Translation by A. McLaren) how Winkler of Dresden had occasion to perform a *triple* ovariotomy, necessitated by the presence of a supernumary ovary, also the seat of a cyst. But had an extra ovary been present I could scarcely have failed to observe it; my ligatures may have slipped, but that I very much doubt, and would offer the following explanation. If one relies on the ordinary text books of anatomy, such as Quain and Gray, an erroneous opinion would be obtained of the true relationship as regards position between the ovaries and fallopian tubes. In both those books very poor drawings of the uterine appendages are given, and the tubes are represented as superior to the ovaries. Flint, relying on Sappey, has the same arrangement, and several others too numerous to mention. Now if we refer to Ramsbotham, a nearer approach to truth is given us. He has the position true, but the best drawing I can find is by the French anatomist Richard, and it has been copied by Playfair, Courty, Lusk, and Lawson Tait. I now pass it round for the members to see it for themselves, as they can thus get a better idea of the true relationship existing as regards position between the tubes and the ovaries than any description can give. I also pass round Tarnièr's "Traite de l'Art des Accouchements," where, on page 115, fig. 51, "Pleis longitudinaux de la trompe utérine," an excellent drawing is also found; and my own experience is more in consonance with Richard and Tarnièr than with Quain and Gray; that is, that you have the three folds of the broad ligament containing anteriorly the broad ligament, in the middle the fallopian tube, and posteriorily the ovary, and that the latter is generally on a level or higher than the tube, *i.e.*, that the ovary is posterior and superior to the tube. To further satisfy myself on the subject, I wrote to my friend and former teacher, Professor Alexander Macalister, of Cambridge, from whom I received the following reply:—

"There is a considerable range of variety in the place of the ovary and fallopian tube; in general the ovary is a little *above*

the fallopian tube. I have not kept accurate statistics, but I should say that this is the case in seventy-five per cent. of subjects. The ovary changes place very little. I believe the fallopian tube is more variable. Of course, the displacement (during pregnancy) of both is considerable, and it depends on surrounding circumstances how the parts settle down afterwards. In the child you will usually find the tube highest, but this alters in adult life; probably the alteration is due to the displacement of pregnancy. I have too little data for determining accurately whether in old virgin subjects the child condition persists invariably or no. I have certainly usually found the tube highest in subjects with persistent hymen, but they are so few that they form too small a basis for generalization."—*A. Macalister.*

I think, therefore, that if we will dismiss the old familiar friends of our youth, where we saw the broad ligament depicted as a single fold of peritoneum containing the fallopian tube at its upper border and the ovary immediately beneath this, and accept in their place the relationship that really exists—namely, that the ovary is contained in a fold of the broad ligament that is usually found posterior and superior to the fallopian tube, you will the more readily accept the explanation which I offer of pregnancy having occurred in the case recorded. It is this, that the strangulation of the ligatures failed to destroy the ovary, which survived, as does the distal portion of pedicle; and the fallopian tube, owing to its anterior and inferior position, not having been included in the ligatures when the latter became absorbed, the uterine appendages at the right side, were in pretty much the same condition that they were in before the ligatures were applied, and therefore capable of performing their functions for conception, for the ovary will go on forming ova even though very much diseased. The case would have been different if the fallopian tube had been included in the ligatures, as then it would almost of necessity have become occluded.

I may add that I have had the advantage of discussing this view of the case with Mr. Knowsley Thornton and with Mr. Lawson Tait, and they each regard it as the most probable explanation; and, curiously enough, in the American Journal of Obstetrics for November, is recorded a case in which Batty performed his operation of double oophorectomy with the result that his patient made an excellent recovery, and became pregnant.

In conclusion, sir, I beg to state that I am by no means finished with this case yet, as Dr. Adamson and I expect to have another ovariotomy on her (for which as yet there is no occasion), and if we do we shall be glad to record what we find.

REPORT OF A CASE OF GASTROSTOMY, WITH REMARKS.

By G. H. HUME, M.D., Surgeon to the Newcastle Infirmary.

Gastrostomy, or the formation of a fistulous opening into the stomach for the introduction of food, is an operation on which there hardly exists an established surgical opinion, and it is right that at present every case should be reported; and, in addition, the following case, although unsuccessful, offers several points of interest which will justify its being brought under your notice:—

Edward H., 37, a butler, had been suffering from stricture of the æsophagus for 12 months. I first saw him in the country, on the 5th of October of this year, with Dr. Stewart of Hexham. The history given to me was that H., piqued by some slight on the part of a fellow-servant, had swallowed a quantity of pure hydrochloric acid. For some weeks afterwards he was kept alive by enemata, and, when swallowing again became possible, only milk could be got down. Since then he has taken almost nothing but milk, and for several months previous to my seeing him he had been able to take less and less. Occasionally for days he could swallow nothing; then the ability seemed suddenly to return, and before it was again lost he would manage to get down, sip by sip, a considerable quantity. I never before saw a man so thoroughly the picture of starvation. He was wasted to a skeleton; his temperature was below normal; the pulse small and unsteady; the sclerotic was of pearly whiteness, and this, with a peculiar searching look, that seemed to come of the cravings of his unsatisfied hunger, gave his face a very striking expression. It was evident that unless something could be done for his relief life could not be long continued. Persevering efforts had been made by Dr. Stewart to pass a bougie into the stomach; but although the instrument could be pushed with slight pressure through a first and second stricture, there existed a third at the lower end of the æsophagus, which could not be traversed. My own efforts were not more successful. A stricture opposite the cricoid cartilage, and one a few inches lower down, yielded readily; but about three inches from the cardiac orifice the end of the bougie appeared to enter a pouch, out of which no aperture of exit could be found. The patient's sensations in attempting to swallow indicated also that the tube had become dilated at this part. It seemed to him that a considerable quantity of milk would sometimes rest there, and then either trickle slowly into the stomach or be rejected. Taking into consideration the urgency of the man's general condition, and the unlikelihood of any good resulting from continued attempts to dilate the strictures, I felt justified in urging that gastrostomy should be performed as soon as possible.

After a few days' consideration the patient came into Newcastle, and the first stage of the operation was performed on October the 12th. I was assisted by Dr. Stewart and Mr H. Jackson, of Hexham, by Dr. Purdie, of Gateshead, and chloroform was administered by Dr. Limont. The details of the operation were similar to those in the case which I communicated to the Society last session. Bryant's line of incision was adopted; and when the left lobe of the liver, which came into view on opening the abdomen, was pushed aside, the stomach was easily found. A portion of its wall, as near to the cardiac end as possible, was brought forward into the wound and held in position by a silk thread, while the stitches were being passed. These were eight or ten in number, and were passed through all the structures of the abdominal wall, and part of the thickness of the stomach wall. The ends of the abdominal incision were then brought together. The suture made use of was silkworm gut. During the operation the exhausted state of the patient showed itself in a constant tendency to stoppage of both pulse and breathing, and artificial respiration had at one stage to be kept up for some time when both had apparently quite ceased. To Dr. Limont's care and skill in giving the anæsthetic I am bound to acknowledge my great indebtedness.

The patient rallied very imperfectly after the operation. He slept a little, however, in the night, and improved somewhat during the following day. An enema of peptonised beef tea and brandy, and a Slinger's suppository, was given at regular intervals. But these were not well retained, and seemed to have very little effect in maintaining strength. On the third and fourth days he rallied a little, but on the fifth it was evident that the second stage of the operation could not be longer delayed. When the antiseptic dressings were removed the wound was seen to be absolutely inactive. It looked like an incision made and stitched up *post-mortem*, and there was not the slightest formation of lymph over the exposed portion of the stomach. The puncture of the stomach wall was made with a teuotomy knife, and was just sufficient to admit a No. 9 gum-elastic catheter. About five ounces of warm milk were slowly poured into the stomach. In the evening slight diarrhœa seemed to be provoked by the enemata, which were themselves badly retained. They were, therefore, discontinued, and the stomach-feeding was repeated at intervals, so that almost a quart of milk, with brandy, was given in the 24 hours. On the following day (October 18) the exhaustion seemed if anything to be greater, and in the evening the temperature, which had varied from 97·5 to normal previous to the opening of the stomach, rose to 99·5. On the evening of the 19th it was 100° Fah. Matters remained much in this condi-

tion for the following day or two. The tongue was thickly coated; there was slight fever, with restlessness, and a pulse that varied with the slightest movement. On the 23rd (the 11th day) the salicylic wool with which the wound was dressed was found to be soaked with a thin sero-purulent discharge. The wound had opened to the inner side of the attached portion of the stomach, and through the opening a probe could be passed into a cavity between the stomach and diaphragm. The probe could not be passed downwards into the general peritoneal cavity, as the stomach wall had apparently now become adherent at this part. A drainage tube six inches in length was at once passed through the opening to the bottom of the cavity. None of the stitches had as yet been removed. During the week following the occurrence of this discharge, a very slow but decided improvement took place in the patient's condition. The pulse fell from 100 to 76 or 84; the temperature from 100·5° F. to 99° F., or sometimes normal. The tongue became clean, and the thirst, which had been a constant torment, was relieved. But the state of the wound was never satisfactory. So soon as any appearance of granulation showed itself, which was not till the 26th (14th day), the outer part of the wound threatened to gape, and an opening became established on this side also of the attached portion of the stomach, and communicated with the cavity below the diaphragm. Through this opening a long drainage tube was passed as on the inner side. For a few days there were some signs of healthy action about the wound. The discharge, both from it and from the cavity, became better in character, and the stomach wall was becoming firmly adherent, both above and below. The cavity was kept as free of discharge as possible by frequent emptying with the syringe and soft tube, and by washing out with different antiseptic fluids. That which seemed to answer best was weak iodine water, and the mode of dressing the wound which appeared most favourable to its healthy action was the application of iodoform ointment on lint covered by an abundant pad of salicylic wool.

This state of things continued till Nov. 2 (21st day), when an untoward change showed itself in the appearance of the wound. A thick pellicle or diphtheritic membrane began to form over it, and a blush of erysipelatous redness spread around the margin. From this the course was very slowly but steadily downward. The wound underwent no improvement. The membrane, when removed, quickly reformed, and there was no attempt at granulation. Previous to this the patient's appearance had improved; his face had rounded, and his expression had become more cheerful. I had been able cautiously to increase the amount of nourishment introduced into the stomach by the addition of an egg in milk, and chicken-tea, and beef-tea thickened with arrowroot. But the

stomach now became less tolerant of food, and would bear only a moderate quantity of milk and brandy. Almost to the last there was not any tendency to escape of food or fluids from the stomach. The small opening closed thoroughly after the removal of the feeding tube, and during the few days when the wound looked somewhat better, the position of the opening was indicated only by a large granulation. Only during the last three days of life the opening tended to gape after each withdrawal of the tube, and there was a troublesome escape of the stomach's contents.

For almost a fortnight the patient seemed to stand still rather than visibly to retrograde ; but on the 16th November (35th day) he appeared to have taken cold. There was not at first much cough, but rather the signs of a coryza ; and on looking into his throat I discovered a diphtheritic patch on the left tonsil. In the following night the cough became constant and exhausting, and it harrassed him at intervals during the ensuing day, though there was not much to be detected in the chest to account for it. It ceased, however, two days before death, which took place on the 19th November—38 days after the operation.

I was permitted to make only a partial examination. The stomach was found to be firmly adherent for some distance from the edge of the wound, and the discharging cavity above the stomach was completely shut off from the rest of the peritoneal cavity. Its closure had been effected by the stomach having become adherent in front, and by the liver adhering to both the abdominal wall and the diaphragm. The stomach was full of dark fluid, and its walls seemed softened. The opening was in the anterior wall, nearer to the cardiac than the pyloric end. There was no sign of peritonitis in the lower part of the abdominal cavity.

Several points of interest are suggested by this case. One is tempted, first of all, to think of the causes which led to an unsuccessful issue ; and there can be no doubt that the primary cause was the extreme exhaustion of the patient at the time of operation. But I think a further question arises as to the condition of the wound which became developed. Was this diphtheritic condition the inevitable state of a wound communicating with an open peritoneal cavity, of which there was not vital force enough left to effect the closure? Or was it due to some septic influence originating in an insanitary state of the house in which the patient was lodged? The latter supposition gains probability from the fact that the room in which he lay adjoined a water-closet which was evidently not in a safe condition ; and it is supported also by the appearance of the patch of membrane on the tonsil, though this may have been the result of a self-infection from the wound.

It is interesting to speculate whether it could have been possible for the cavity in the upper part of the abdomen to close. The history of ovarian cases proves that limited peritonitis, discharging externally, may quite well be recovered from. But a cavity in the upper part of the belly is peculiarly ill-situated for closure. The firm chest wall, the constantly-moving diaphragm, and the comparatively fixed liver and stomach in this case afforded little facility for an approximation of the sides of the cavity. But during the week, when the state of the patient improved, there was a decided lessening of the cavity and discharge, so that had strength remained I am inclined to think that the local conditions did not exclude the possibility of recovery.

In considering the claims of gastrostomy to become an established operation, it must be borne in mind that it is practised in two different kinds of cases. As a means of relieving suffering and prolonging life in malignant stricture of the œsophagus, it is necessary to consider mainly the question whether the degree of danger attending the operation is worth incurring for the relief and extension of life likely to be obtained. And the answer to this question seems to be that if the operation be done sufficiently early the gain is worth the risk. In cases of cicatricial stricture the object in view is a more indefinite prolongation of life; and in these cases the fatality of the operation can be more accurately estimated, as the condition for which it is performed is not one in itself fatal.

But even in this class of cases the results have so far been most unsatisfactory. From various sources I have been able to collect a list of 24 cases of gastrostomy performed since 1876, either for traumatic or syphilitic stricture, and of these only 10 have been successful. Amongst the successful cases I have included only those in which a fistula was established and the wound perfectly cicatrised. To attempt an analysis of the causes of death in the unsuccessful cases would occupy too long, but one or two facts may be shortly stated. Of the 14 fatal cases death occurred in eight, at periods from a few hours to three days after the operation. In six of these eight, death took place within 30 hours. Peritonitis is mentioned as the cause of death in only three of all the cases, so that it may be fairly concluded that in the majority the fatal result was due to shock or exhaustion; or, in other words, that the operation was fatal because delayed until the patient's strength was exhausted. There seems every reason to believe that in this lies the explanation of the high mortality which has as yet attended the operation; and better results cannot be hoped for until it is undertaken so soon as dilatation of the stricture proves impossible, or fails to secure such a facility in swallowing as will permit the patient's strength to be maintained.

OSTEOID CANCER (OR MALIGNANT OSSEOUS TUMOUR) OF KIDNEY.

By JAMES ADAMSON, M.D.

James Bell, æt 68 years, coal miner, had always enjoyed good health and been of temperate habits. On the 24th of September, 1881, he was severely crushed on the left side of the body by a "tub" passing him in a narrow part of the workings. He continued at work for two days afterwards, though suffering considerable pain. When first seen, on the fourth day after the accident, he complained of pain on the left side generally, but especially over the 5th and 6th ribs (aggravated by pressure); he also expectorated small quantities of mucous mixed with blood; the urine was high coloured and deposited blood on standing; he had pain in the left iliac region, but did not complain of pain in the lumbar region.

The symptons having improved, he resumed work seven weeks after the accident, but still complained of pain in the left side of the thorax. He continued at work for about three weeks, when he was again laid up by an attack of pneumonia affecting the left lung. He recovered from this, but then began to complain specially of pain in the left iliac region, shooting back to the loins and down the leg of the same side. The shooting pains in the leg at first occasionally followed the course of the sciatic nerve, but generally that of the obturator, and finally settled in the course of the latter nerve. These pains in the side and leg were paroxysmal, and very severe unless controlled by sedatives. Later there was slight œdema of the foot and leg of the affected side. There was persistent and increasing constipation; patient generally felt relieved after the bowels had been acted on; there was no pain with defæcation; occasionally dulness could be made out on the left side of the abdomen, but this was generally obscured by flatulence. The patient's friends stated that when the paroxysms were exceptionally severe, a "hard lump" could be felt in the abdomen at the site of pain. Finally he became emaciated and cachectic in appearance, and the intervals of freedom from pain gradually diminished until his death, which took place on the 28th June, 1883.

Post-mortem.—The left lung was strongly adherent to the chest walls, especially over the fifth and sixth ribs, at the site of the original injury. There were some adhesions of the right lung; both were strongly pigmented, but otherwise healthy; the heart was healthy, but flabby; the liver was the subject of fatty degeneration; the spleen, congested with blood, was healthy, with the exception of a small cyst on its surface filled with serous fluid; the stomach and bowels were normal; the right kidney of normal size, and healthy. The left kidney was enlarged uniformly to about four times the normal size, its capsule was entire on the upper and part of

the under surface ; sharp spiculæ could be seen and felt projecting under the capsule on the upper aspect of the tumour ; the tumour was connected by a reddish pultaceous mass to the spinal column for three or four inches on its lateral aspect, slightly to the posterior portion of the crest of the ilium on its inner surface, also to the 12th rib, which was found to have been driven inwards to the kidney. On section it was found that the normal structure of the kidney was entirely replaced by a substance of the consistence and appearance of "putty," but slightly darker in colour. This was traversed throughout its entire extent by a fine meshwork of bony tissue, giving way with difficulty to the knife. The cancellous spaces varied from one-quarter to three-quarters of an inch in diameter. There was no visible structure in the ground substance of the tumour. The bones attached to the tumour were denuded of their periosteum and roughended on their surface at the points of attachment, but no bony tissue was found in the soft pultaceous substance which filled up the space between the kidney and the spine. The kidney itself was adherent to the 12th rib at the point where the rib had been driven inwards, and this was probably the starting point of the disease. The growth was probably encephaloid cancer, and this in the kidney was accompanied by a bony stroma sent inwards from the rib.

The diagnosis formed was cancer, probably situated at the sigmoid flexure of the colon.

During the progress of the case there were no symptoms pointing to the kidney as being the site of disease, and the urine was always normal.

The points of interest are —

(1.) Its rarity.

(2.) The bony stroma being confined to the kidney, although the growth itself was not.

(3.) The capsule of the kidney formed the boundary, and seemed to be free from disease.

Dr. Dyce Duckworth desired to ask Dr. Adamson for particulars about the temperature in his case. He had lately had one under his care which appeared, on clinical grounds, to be somewhat similar. In this, and in other cases of like nature, the temperature curve had been observed to follow a peculiar curve. The pyrectic periods were very irregular and intermittent. There was a good mean of exalted temperature, but sharp rises took place, sometimes in the evenings, but more often in the morning. The type corresponded to none of the ordinary recognised curves, and the existence of pyrexia was itself significant of the sarcomatous or lympho-sarcomatous growth, rather than of true cancers.

Dr. Adamson said the temperature had been erratic but never very high.

SEQUEL OF THE CASE OF OBSCURE TUMOUR OF THE BACK OF THE THIGH SIMULATING ANEURISM, SHOWN AT THE OCTOBER MEETING, WITH SPECIMEN AND PATIENT.

By FREDERICK PAGE, Surgeon to the Infirmary, Newcastle-upon-Tyne.

At the October meeting of this Society, I introduced a patient suffering from a very remarkable tumour, situated at the back of the left thigh, and several members were good enough to examine the case, and to give me the benefit of their opinion as to the nature of the growth. I propose, to-day, sir, to relate the further history of the case, and to show the specimen, believing there are many present here, this evening, who will be glad to learn the result of so interesting, and I venture to say so rare, an example of disease. I carried out my intention of cutting into the tumour, having first emptied the limb of blood and cut off the supply by means of Esmach's elastic bandage and tourniquet. Incision through the skin and muscles exposed a sac or capsule. It was opened and found to contain brain-like material of hardly more consistence than porridge. There was enough of this to half fill a wash-hand basin, and it was easily scooped out with the hand. The muscles of the thigh were readily separated from the growth, but neither above nor below could the capsule be freed. The great sciatic nerve above and the popliteals below were incorporated, or at any rate so very intimately associated with the membrane that they could not be dissected out. There being no doubt as to the malignant nature of the disease, I amputated the thigh, dividing the muscles by a circular incision close to the small trochanter and covering the surface with lateral skin flaps. The limb has been carefully examined by Mr. Baigent and Mr. Lazenby, Students of Medicine at the University of Durham College of Medicine, to whom I am indebted for the following report, and for the sections shown under the microscope this evening :—

"The tumour was situated within the substance of the great sciatic nerve, its capsule being formed of the thickened sheath of the nerve. Two inches above the bifurcation of the sciatic the tumour terminated abruptly, and at this situation the nerve was surrounded by a dense band of circular fibres. There was no marked limitation at the upper margin of the tumour. The sciatic above the tumour, and the branches below—even to the plantar nerves—were considerably larger than is usual, and on section harder than natural. Four arteries, as large as the radial, entered the tumour anteriorly.

The femoral artery was firmly adherent to the anterior surface of the capsule; the tumour had no connection with bone or periosteum; the fibres of the sciatic nerve could be seen ramifying and forming prominent rugæ on the internal surface of the capsule. The brain-like material was arranged in lobules (like a bunch of grapes), separated from each other by fibrous tissue, and but loosely connected with the capsule. Microscopic examination showed it consisted principally of small spindle-shaped cells, imbedded in a very scanty connective tissue; the blood vessels were large irregular sinuses without any definite walls, the cells being more closely grouped together around them."

Here is the specimen, or rather a portion of it, for the brain-like material occupying the capsule has been removed, leaving the sciatic nerve and its divisions with the expanded sheath in which the tumour was situated.

The patient is now upon the point of leaving the hospital.

Dr. PHILIPSON referred to a consultation on the case which was held by the united staff of the Infirmary. At that time the majority of the staff were in favour of the tumour being solid, and inclined to the belief that it was a sarcoma. Subsequently, from a pulsation arising in the tumour, it was thought that although the situation of the tumour was not that of any large artery, yet, for an abnormal distribution of the vessels, it might be aneurismal. From what had been stated by Mr. Page, the members would readily understand the great difficulties of the case, and that, even with the greatest care being taken in obtaining information respecting the previous history and progress of the case, a difficulty like what had arisen in the present case might occur.

Dr. MURPHY briefly drew attention to the fact that, although the sciatic nerve was so seriously engaged in the tumour, there was but little or no pain, and not the slightest appearance of paralysis at any time.

Dr. HUME drew attention to the manner in which the growth had so closely simulated one of the signs of an aneurism. The tumour consisted of a firm fibrous bag, containing soft spongy material full of blood. When the femoral artery was compressed, and the blood supply cut off, the bag became flaccid, and when pressure was removed the bag refilled with the same sudden expansion as happens in the case of an aneurismal sac.

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ERRATA.

The following (omitted accidentally from Dr. Philipson's remarks on Pneumonia in the November number) should come in after "manifested" (line 12, p. 83):—

. . . It was further argued, that this was not fatal to pneumonia being regarded as a specific disease, because there were certain diseases, non-contagious, which undoubtedly were dependent upon a change in the quality of the blood, the *materies morbi* so circulating. Of such diseases rheumatic fever and acute tonsillitis were instanced. Rheumatic fever was believed to be a specific febrile disorder attending a morbid state of the system, dependent upon a poison in the blood, not derived from without, and expressed by a peculiar inflammation of the fibrous tissues. In acute tonsillitis shivering and fever . . . . . .

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